STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 01/17/2019

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

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E 000	Initial Comments	E 000		

MEDICARE COMPLAINT SURVEY

The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation for Hospitals set forth in 42 CFR 482, conducted this health and safety survey.

Onsite dates: 01/08/19 to 01/11/19 and 01/15/19 to 01/17/19

Intake number: 87038

The survey was conducted by:

Surveyor #2
Surveyor #3
Surveyor #5
Surveyor #9
Surveyor #10
Surveyor #11

A state hospital licensing survey (Examination number 2018-978) was also conducted with this Medicare Complaint Survey.

DOH staff found the facility NOT IN COMPLIANCE with the following Conditions of Participation:

42 CFR 482.12 Governing Body

42 CFR 482.21 Quality Assessment and Performance Improvement

42 CFR 482.23 Nursing Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X [signature]	CEO	2/13/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 037	EP Training Program CFR(s): 482.15(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 2 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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E 037	Continued From page 4 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that staff received training at orientation or annually regarding the hospital's emergency preparedness program consistent with expected roles of each staff for 9 of 9 staff members reviewed (Staff #205, #206, #207, #208, #209, #213, #214, and #215). Failure to ensure that staff are trained on the hospital's emergency preparedness plan and their expected roles during an emergency risks delayed response, injury or death to staff and patients in the event of an emergency. Findings included: 1. Record review of the hospital policy titled, "Emergency Operation Plan," reviewed 05/08/18, showed that staff identified in critical areas will receive appropriate training on the Incident Command System and the National Incident Management System. The policy does not mention all-staff training or required intervals for that training. Record review of the emergency preparedness	E 037		

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E 037	Continued From page 5 program documents did not show any employee training materials or documentation. 2. Record review of the personnel files for four registered nurses (Staff #205, #206, #207, and #209), two mental health technicians (Staff #213 and #214), two licensed practical nurses (Staff #215 and #216), and one program therapist (Staff #208) showed that there was no documentation of having completed emergency preparedness training in their personnel files. 3. On 01/16/18 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who also serves as the hospital clinical educator regarding staff emergency preparedness training. Staff #210 stated that the facilities department should handle emergency preparedness training for all staff. She confirmed that the emergency preparedness trainings were not a part of the normal hospital orientation or annual training process.	E 037		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, document review, and interview, the hospital's governing body failed to provide effective oversight of the hospital	A 043		

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A 043	Continued From page 6 Failure to provide effective oversight to prevent substandard practices for quality care, patient safety, pharmacy services, and nursing services resulted in an unsafe environment for patients. Findings included: The hospital failed to develop a hospital-wide quality assessment and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through systematic data collection and analysis, and implementation and monitoring of quality activities. Cross Reference: A0263 The hospital failed to ensure sufficient numbers of nursing staff were available to provide safe and effective care for patient's health care needs Cross Reference: A0385 The hospital failed to maintain ongoing compliance with previously cited deficient practices. Cross Reference: A068, A0144, A0263, A0273, A0286, A0308, A0385, A0392, A0396, A0405, A0749 Due to the cumulative effect of the deficiencies detailed under 42 CFR 482.21 Condition for Participation for Quality Assessment and Performance Improvement Program and 42 CFR 482.23 Condition of Participation for Nursing Services, the Condition of Participation for Governing Body was NOT MET	A 043		

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A 043	Continued From page 7 THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 03/15/18, 06/07/18, AND 07/17/18. .	A 043		
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures the Governing Body failed to develop and maintain effective systems that ensured that patients received quality healthcare that met their needs for 2 of 3 patients with Diabetes Mellitus reviewed (Patient #501 and #503). Failure to provide patients with medical services that meet the patient's healthcare needs risks	A 068		

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A 068	Continued From page 8 deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. Document review of the hospital's document titled, "Medical Staff Rules and Regulations," dated 04/17, state that the attending physician shall assume and accept full responsibility for the quality of the clinical care for his/her patients ....the admitting physician must give complete orders including but not limited to precautions to be followed and labs to be drawn. Document review of the hospital's document titled, "Smokey Point Behavioral Hospital Governing Board Bylaws and Constitution," dated 06/17, states that the Governing Board is ultimately accountable for the quality of patient care, treatment, and services. 2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The review showed: -The Psychiatric Evaluation completed on 01/06/19 showed a medical history of Diabetes Mellitus Type 2. -The Initial Medical Consultation completed on 01/06/19 showed a medical history of Diabetes Mellitus Type 2 and a blood sugar of 387 in the Emergency Room prior to admission to the psychiatric hospital. -On 01/06/19 at 4:40 PM, a provider order directed nursing staff to check the patient's blood	A 068		

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A 068	Continued From page 9 sugar level twice daily. The provider's order did not provide direction for staff response to the patient's blood sugar level. -Review of blood sugar documentation on the medication administration record from 01/06/19 until 01/08/19 showed the patient's blood sugar level ranged from 157 mg/dl to 240 mg/dl. Surveyor #5 found no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels. 3. At the time of the observation, Surveyor #5 asked the Registered Nurse (RN) (Staff #505) at what blood sugar levels did he need to notify the provider. Staff #505 stated that he did not know what the blood sugar parameters were and he would need to look at the policy. A search for a policy revealed there was no policy or protocol that addressed blood sugar management or parameter to notify the provider. Staff #505 verified there were no provider orders to direct staff when to notify the provider and no orders to treat high or low blood glucose levels. 4. On 01/09/19 at 9:25 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #511), and a Licensed Practical Nurse (Staff # 512) reviewed the medical record of Patients #503. Patient #503 was admitted for suicidal ideation with intent to harm oneself, major depression, and visual hallucinations. The review showed: -The Psychiatric Evaluation completed on 01/04/19 showed a medical history of Diabetes Mellitus Type 2 -The Initial Medical Consultation completed on	A 068		

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A 068	Continued From page 10 01/04/19 showed a medical history of Diabetes Mellitus Type 2. -On 01/04/19, a provider ordered blood sugar checks in the morning and before the patient's evening meal. -Review of blood sugar documentation from 01/04/19 until 01/09/19 showed the patient's blood sugar level ranged from 122 mg/dl to 299 mg/dl. Surveyor #5 found no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels. 4. At the time of the observation, Surveyor #5 asked the LPN (Staff #509) at what blood sugar levels did she need to notify the provider. Staff #509 stated that there was an, "element of judgement." Staff #509 verified there were no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels. 5. On 04/16/19 at 4:45 PM, a Physician (Staff #513) provided Surveyor #5 with a copy of a document titled, "Data Entry for Blood Glucose Quality Control," dated 06/17. Staff #513 stated this was a form adopted to guide staff about when to call the provider for low and high blood sugars. Surveyor #5 reviewed the form and noted it was a quality control form for checking controls on the blood sugar machines. It included a column for the control chem-strip lot number, expiration date and code number. It contained a column for acceptable control ranges for low and high that were define above the column as "low range would be 29-59 mg/dl and the high range should be 222-371 mg/dl." It also contained a column to	A 068		

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A 068	Continued From page 11 document cleaning and maintenance of the machine. Surveyor #5 found no evidence that this form was an order or protocol to direct staff when to notify a provider of low or high patient blood sugar levels. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18, 06/07/18, 07/12/18, 08/22/18, AND 09/12/18.	A 068		
A 119	PATIENT RIGHTS: REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2) [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital failed to ensure review and resolution of a patient grievance went through the grievance committee for 1 of 2 grievances reviewed. Failure to review and approve resolution of grievances by a committee instead of an individual risks incomplete or inadequate evaluation of all aspects of the grievance issue. Findings included: 1. Document review of the hospital's policy and procedure titled, "Grievances and the Patient	A 119		

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A 119	Continued From page 12 Advocate," no policy number, effective 05/17, showed that the patient advocate will investigate all complaints received from patients and others. Each patient making a complaint and others making a complaint will receive a response from the facility staff that addresses the complaint in a timely manner (within one week). A written response is to be provided within 30 days of the filed grievance. The Chief Executive Officer shall have final authority and responsibility in resolving grievances. 2. On 01/16/19 at 1:50 PM, Surveyor #3 interviewed the Director of Quality and Risk Management (Staff #308) about the grievance investigation and resolution process. Staff #307 stated grievances are investigated and reported through the performance improvement and grievance committees. The grievance committee consists of the Chief Executive Officer, the Chief Financial Officer, the Chief Nursing Officer, the Program Directors, and the Chief of Clinical Services. The grievance committee meets monthly. 3. On 06/16/2018 at 2:00 PM, Surveyor #3 reviewed the 2018 grievance log. The surveyor observed that two grievances had been filed in December with one remaining open. The surveyor asked Staff #308 if the one closed grievance filed in December had gone through the grievance committee process. Staff #308 stated the grievance had not gone through the grievance committee. Staff #308 reviewed, investigated, and closed the grievance himself rather than referring it to the grievance committee.	A 119		

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A 144	Continued From page 13	A 144		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview, record review, and review of hospital policy and procedures, the hospital staff failed to implement its policies and procedures when contraband was discovered in a patient's room for 1 or 1 records reviewed (Patient #903). Failure to report, investigate, and prevent contraband and other hazardous items from entering the hospital risks patient, visitor, and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Room Searches," no policy number, revised date 06/18, showed that hospital staff members would search patient rooms for contraband at least twice daily. Contraband included prohibited items such as illegal drugs and paraphernalia. The policy showed that when staff discover contraband, hospital staff would confiscate the items; immediately notify the patient, the patient's healthcare provider, and the Chief Nursing Officer; and complete an incident report. 2. On 01/10/18 at 2:30 PM, Surveyor #9 interviewed a Registered Nurse (RN) (Staff #905) regarding an allegation that Patient #903 had brought contraband into the hospital. He stated that on 12/24/18 he received a note from a patient stating that there were "drugs on the unit."	A 144		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 144	Continued From page 14 The nurse conducted a room search and found some small blue rubber pieces with a white residue. The nurse contacted the Chief Nursing Officer (CNO) (Staff #906) at the time of the discovery. Staff #905 also shared this information with the healthcare providers in their treatment meeting that day. As a result, the involved patient's provider wrote an order for the patient to be on unit restriction and placed on 5-minute observational monitoring. 3. Staff #905 stated that around 10 AM on 12/24/18, he observed Patient #903 to be pale, sweating, and complaining of right lower quadrant abdominal pain. The nurse contacted the provider who directed the patient to be sent to a local emergency room for diagnosis and treatment. The patient's subsequent diagnosis was determined to be constipation. In addition, it was determined the patient tested positive for amphetamines. On 12/26/18, Staff #905 conducted another room search. During the search, a white powder in a plastic bag was found in Patient #903's pant pocket. The patient was confronted and stated that the powder was Suboxone (a medication used for opioid dependence). The patient stated he had received it during an emergency room visit prior to being admitted at the psychiatric hospital. The staff had not found or detected the medication during the initial admission process. The RN placed the plastic bag in a specimen container and marked it with the patient's name, date and time found. The RN gave the item to the CNO and wrote a progress note on 12/26/18 detailing what he found in the patient's room. 4. The RN stated that he also filled out an	A 144		

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A 144	Continued From page 15 incident report regarding the search findings. The surveyor was unable to find a incident report regarding this incident nor the incident on 12/24/18 despite a review of the hospital's incident report logs. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18, 06/07/18, 07/17/18, AND 09/12/18.	A 144		
A 171	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(8) Unless superseded by State law that is more restrictive— (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Based on record review and review of hospital policies and procedures, the hospital failed to ensure staff appropriately ordered the correct time limits for restraint use or seclusion based upon the patient's age for 1 of 6 records reviewed (Patient #1001). Failure to order the correct time of restraint or seclusion duration places patients at risk for physical and psychological harm, loss of dignity,	A 171		

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A 171	Continued From page 16 and violation of patient rights. Findings included: 1. Review of the hospital's policy titled, "Use of Seclusion," no policy number, effective 05/17 showed that the use of seclusion requires a time-limited Physician order. For ages 9 -17 years old, the time duration is two hours. For those 18 and older, the time duration is four hours. The policy showed that in the event of an emergency, a trained nurse may make the decision to initiate seclusion. 2. A review of Patient #1001's medical record showed a 13-year old patient admitted to the adolescent unit for management of a mental health disorder. On 12/01/18 at 2:45 PM, the patient was observed punching the wall, resulting in harm to himself as staff attempted to de-escalate the situation. The review showed that the patient initially was held manually from 2:45 PM - 2:50 PM and then placed in seclusion from 2:45 PM - 3:00 PM. The nurse obtained a verbal order from a licensed provider at 3:30 PM, but the time limit ordered for this event was noted to be for an adult with a maximum of 4 hours of seclusion. Since the patient was a 13 year old, the order should have been limited to two hours of seclusion, plus continuous assessment, by staff, to ensure release from seclusion was done at the earliest possible time, as required.	A 171		
A 196	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(1) Training intervals. Staff must be trained and able	A 196		

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A 196	Continued From page 17 to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that contracted nursing staff received restraint and seclusion training as part of their orientation and at regular intervals for 1 of 3 agency records reviewed (Staff #205). Failure to ensure staff receive orientation in restraint and seclusion training places patients at risk for violations of their rights, unsafe care, and potential injury from improper restraint and seclusion application. Findings included: 1. Record review of the hospital policy titled, "Staff Training," no policy number, revised 09/18, showed that staff are to receive initial and ongoing training on restraints and seclusion. Human resources is responsible for maintaining documentation of all training completed by staff. 2. Record review of employee personnel and training files for one agency registered nurse (Staff #205) who started 10/23/17, showed that the staff member did not have any documentation of in-service training for restraint or seclusion including least restrictive alternatives to their use.	A 196		

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A 196	Continued From page 18 3. On 01/16/18 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the hospital clinical educator, regarding the training files for Staff #205. Staff #210 stated that staff have 90 days to complete orientation and that restraint and seclusion in-service training occurred in October of 2018. Staff #210 confirmed that no training files for restraints and seclusion orientation or in-service training were in the employee personnel file. The hospital was unable to provide any training checklist or other documentation to confirm that Staff #205 had completed restraint and seclusion training.	A 196		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by:	A 263		

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A 263	Continued From page 19 Based on observation, interview, and review of quality documents, the hospital failed to develop a hospital-wide quality assessment and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through systematic data collection and analysis, and implementation and monitoring of quality activities. Failure to systematically collect and analyze hospital-wide performance data limited the hospital's ability to identify problems and formulate action plans. This reduced the likelihood of sustained improvements in clinical care and patient outcomes. Findings included: The hospital failed to ensure review and resolution of a patient grievance went through the grievance committee. Cross Reference A0119 The hospital failed to ensure that data regarding medication errors, assaults, and patient falls, were analyzed for patterns, trends, and common factors through the hospital's quality program. Cross Reference A0273 The hospital failed to develop and implement performance improvement activities and action plans that supported hospital quality indicators related to patient safety and quality of care. Cross Reference A0283	A 263		

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A 263	Continued From page 20 The hospital failed to ensure corrective actions for identified adverse events were implemented and monitored for effectiveness. The hospital failed to ensure corrective actions for identified adverse events were implemented and monitored for effectiveness. Cross Reference A0286 The hospital failed to develop and implement a coordinated, integrated hospital-wide quality assessment and performance improvement plan. Cross Reference A0308 The hospital failed to ensure sufficient numbers of nursing staff were available to provide safe and effective care for patient's health care needs. Cross Reference A0385 The hospital failed to ensure that contracted nurses received documented hospital orientation and the hospital failed to ensure that annual agency staff performance evaluations were conducted. Cross Reference A0398 The hospital failed to ensure that patients with medical conditions or histories that necessitate dietary consults received consults or that consults ordered by dieticians were conducted. Cross Reference A0629 The hospital failed to ensure that contracted staff were oriented on infection control.	A 263		

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A 263	Continued From page 21 The hospital failed to ensure that staff members placed patients with infectious disease diagnosis in appropriate precautions to prevent transmission of infections. Cross Reference A0749 Due to the scope and severity of these deficiencies, the Condition of Participation at 42 CFR 482.21, Quality Assurance, and Performance Improvement was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 03/15/18.	A 263		
A 273	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of	A 273		

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A 273	Continued From page 22 services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: . Based on interview, review of the hospital's quality program and review of quality documentation, the hospital failed to ensure that data regarding medication errors, assaults, and patient falls, were analyzed for patterns, trends, and common factors through the hospital's quality program. Failure to collect, aggregate and analyze data to improve patient outcomes puts patients at risk of substandard care. Findings included: 1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to: -determine if there are opportunities for improvement, -to identify suspected or potential problems, -to prevent or resolve problems, -to set process improvement priorities, -and to monitor effectiveness of actions taken	A 273		

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A 273	Continued From page 23 The hospital will utilize comparison of outcome and process data to ensure that the same level of care is provided regardless of geographic location in the hospital where care is provided. 2. On 01/10/18 at 5:00 PM, Surveyor #5 reviewed the hospital's document titled, "Quality Dashboard 2018." Surveyor #5 noted that the hospital's quality indicator data including falls, assaults, contraband, employee injuries, medication errors, self-harm, and infections were presented in a line-listed format without aggregation or analysis. The hospital did not stratify data by geographic location for comparison as directed by the hospital's Quality Plan. 3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program and PI committee meeting minutes. Review of the PI committee minutes showed the hospital did not aggregate performance improvement indicator data, stratify data by geographic location, set benchmarks, set targets for improvement, or perform statistical analysis as directed by the hospital's Process Improvement Plan. 4. At the time of the review, Staff #513 and Staff #514 confirmed the finding and stated that the plan and the format of the minutes needed to be re-evaluated. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18.	A 273		
A 283	QUALITY IMPROVEMENT ACTIVITIES	A 283		

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A 283	Continued From page 24 CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that– (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on interview, document review, and review of quality data, the hospital failed to develop and implement performance improvement activities and action plans that supported hospital quality indicators related to patient safety and quality of care. Failure to develop projects and action plans based on results of data collection aimed at improving patient outcomes puts patients at risk from harm due to substandard care.	A 283		

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A 283	Continued From page 25 Findings included: 1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to: -determine if there are opportunities for improvement, -to identify suspected or potential problems, -to prevent or resolve problems, -to set process improvement priorities, -and to monitor effectiveness of actions taken. The document further states that assessment activities carried out by the program included data assessment to identify opportunities for improvement and facilitate setting of priorities and comparison of outcome and process data to ensure that the same level of care is provided regardless of geographic location in the hospital where care is provided. 2. On 01/10/18 at 5:00 PM, Surveyor #5 reviewed the hospital's document titled, "Quality Dashboard 2018." Surveyor #5 noted that the hospital's quality indicator data including falls, assaults, contraband, employee injuries, medication errors, self-harm, and infections were presented in a line-listed format without aggregation or analysis. The document showed 31 falls, 88 assaults, 33 instances of contraband, and 26 employee injuries. The hospital did not stratify data by geographic	A 283		

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A 283	Continued From page 26 location for comparison as directed by the hospital's Quality Plan. 3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program and PI committee meeting minutes. Review of the PI committee minutes showed the hospital did not aggregate performance improvement indicator data, stratify data by geographic location, set benchmarks, set targets for improvement, or perform statistical analysis as directed by the hospital's Process Improvement Plan. Because the hospital failed to aggregate and analyze its quality indicator data, it was unable to identify problems or potential problems, set process improvement priorities, and develop corresponding process improvement action plans and monitoring plans. 4. At the time of the review, Staff #513 and Staff #514 confirmed the finding. Staff #514 stated that the hospitals PI plan would need to be re-evaluated to include the required elements.	A 283		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and	A 286		

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A 286	Continued From page 27 track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to identify, track, and investigate patient safety events as directed by its process improvement plan for 9 of 13 patient safety events (Item #1) and failed to implement and evaluate effectiveness of corrective actions for previously identified adverse events (Item #2). Failure to identify and analyze data to determine factors that contribute to patient injury can result in an unsafe healthcare environment. Item #1 - Patient Safety Event Reporting and Investigation Findings included: 1. Document review of the hospital's document	A 286		

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A 286	Continued From page 28 titled, "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan) no policy number, no approval date, identified performance improvement indicators including "incidents, adverse events, sentinel events, and critical incidents." The document stated that the PI committee is responsible for providing oversight of the hospital's systems for process improvement, including clinical outcomes, evidence based practice, resource utilization and patient safety. The committee will receive reports from Risk and Safety, and use data sources in evaluation of the need for quality improvement teams. The Manager of PI and Risk is authorized to conduct any necessary investigation in cases of significant incidents or sentinel events. Any events requiring root cause analysis and process improvement are reported to the PI committee for monitoring and follow-up. 2. During medical record review from 01/08/18 through 01/13/18, Surveyor #3, Surveyor #5, Surveyor #9, and Surveyor #10 identified 13 patient safety incidences. Review of the hospitals incident report log showed that 9 of the 13 safety incidents were not identified, logged into the incident reporting system, or investigated. The events identified included: a. Patient #505: Suicide Attempt on 10/04/18 b. Patient #506: Suicide Attempt on 11/22/18 c. Patient #507: Suicide Attempt on 12/02/18 d. Patient #508: Sexual Victimization (female adolescent patient touched inappropriately and	A 286		

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A 286	Continued From page 29 without permission by a male peer) 12/09/18 and 12/10/18 e. Patient #509: Medication Error on 12/13/18 f. Patient #510: Assaulted Staff, threw furniture, and required a police response on 12/16/18 g. Patient #511: Assaulted a peer on 12/21/18 h. Patient #512: Ingested Contraband resulting in patient transfer to hospital on 12/24/18 i. Patient #513: Medication Error (six missed doses) started on 01/03/19 3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and the Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality and safety program. Surveyor #5 compared the incident report log provided by the hospital with these incidences and noted the incidences had not been identified, logged, or investigated. Staff #513 and #514 confirmed the finding and stated that the process they have in place at this time for identifying and managing incidents is not effective. Item #2 - Adverse Events Corrective Action Monitoring Findings included: 1. Document review of the hospitals policy and procedure titled, "Root Cause Analysis," no policy number, effective date 05/17, showed that the Root Cause Analysis (RCA) must identify who is	A 286		

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A 286	Continued From page 30 responsible for monitoring whether the change has been implemented, at what frequency the monitoring will occur, and how the effectiveness of the change will be evaluated, including who will be responsible and what indicators will be used. Document review of the hospital's document titled, "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that sentinel events and significant incidences requiring root cause analysis and performance improvement activities are reported to the Process Improvement Committee for monitoring and follow-up. 2. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and the Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality and safety program including the hospital's adverse event log for year 2018. The log showed two events reported for 2018. Surveyor #5 reviewed the two RCA's and noted that the hospital initiated corrective action plans for 1 of 2 of the reported adverse events. Surveyor #5 found no evidence the hospital monitored or reevaluated the corrective action plans to determine effectiveness of the interventions or measurable progress toward the established goals. 3. At the time of the review, an interview with Surveyor #5, Staff #513 and #514 confirmed the finding. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18 AND 06/07/18. .	A 286		

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A 308	QAPI GOVERNING BODY, STANDARD TAG CFR(s): 482.21 ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: . Based on interview, document review, and review of the hospital's quality and performance improvement program, the hospital failed to develop and implement a coordinated, integrated hospital-wide quality assessment and performance improvement plan. Failure to develop a coordinated process to oversee the performance of all patient care services and departments risks provision of improper or inadequate care and adverse patient outcomes. Findings included: 1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to determine if there are opportunities for improvement, to identify suspected or potential problems, to prevent or resolve problems, and to monitor effectiveness of actions taken. The objective of the plan is to ensure coordination and	A 308		

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A 308	Continued From page 32	A 308		

integration of all quality improvement activities by maintaining a PI Committee that all quality improvement information will be exchanged and monitored.

2. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program. The review showed:

-The program did not include or evaluate performance metrics for the hospital's clinical contracted services. There was no mechanism for reporting process improvement recommendations through the hospital's Quality Committee.

-The program did not include or evaluate performance metrics for the hospital's Pharmacy Services. The quality review process for Pharmacy Services was not part of the hospital's quality and performance improvement program. Surveyor #5 found no evidence medication error data was aggregated, analyzed, or monitored for effectiveness of actions taken to reduce medication errors through the hospital's quality program.

3. At the time of the review, Staff #513 and Staff #514 confirmed the findings.

4. On 01/16/19, Surveyor #9 reviewed the Pharmacy and Therapeutics Committee (P & T) meeting minutes for September 2018, October 2018, and November 2018. Surveyor #9 found no evidence that medication errors or near misses had been aggregated, trended, or reported

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A 308	Continued From page 33 through the Quality Committee. Surveyor #9 observed that the P& T minutes dated 11/29/18 stated "Future medication errors will need to be trended and analyzed for opportunities for improvement." 5. On 01/16/19 at 10:30 AM, during an interview with Surveyor #9, the Pharmacy Director (Staff #908), stated that he was recently hired by the hospital on 11/29/18. He acknowledged that prior to his arrival, medication errors had not been aggregated or trended nor had medication errors been reported to or monitored by the hospital Quality Committee. 6. On 01/16/19 at 1:00 PM, Surveyors #2, #3, and #5 interviewed 3 of 7 voting members of the governing body which included the Chief Executive Officer (CEO) (Staff #309), the Chief Financial Officer (Staff #310), and the Senior Vice President for Clinical Compliance (Staff #311). Other hospital staff in attendance included the Chief Nursing Officer (Staff #306) and the Chief of Quality & Risk (Staff #308). Surveyor #3 asked how the Governing Body ensured the hospital remained in compliance with the conditions of participation following the September 2018 revisit. In addition, the surveyor asked what actions have the hospital taken to sustain its compliance efforts given the current on-site survey team is finding similar findings to previous visits? Staff #311 stated a member of the governing body has been on-site at this hospital almost continuously since the March 2018 survey. Staff #311 also stated the corporate leadership recognizes there are problems and is trying to address them. She stated that after the hospital came into compliance, the hospital replaced the CEO in late September. It has replaced the Chief Medical	A 308		

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A 308	Continued From page 34 Officer after the former resigned in October. Finally, the CEO brought in a new CNO in late November to make additional changes. The CEO (Staff #309) stated that she initially noticed many broken processes and looked at each area. She stated there was a need to reorganize the hospital structure. She acknowledged there were daily discussions with the corporate headquarter's leadership regarding the hospital operations. Staff #309 stated there has been tremendous transitions with staffing as result of turnover and on-boarding. She participates in weekly corporate operation meetings, which includes review of several reports both weekly and monthly. Surveyor #5 stated that she found no evidence in the Governing Board Minutes to reflect these daily or weekly discussions. Staff #311 confirmed that the documentation "could be better." THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18.	A 308		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: . Based on observation, interviews, and document reviews, the hospital failed to ensure sufficient numbers of nursing staff were available to provide	A 385		

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A 385	Continued From page 35 safe and effective care for patient's health care needs. Failure to provide enough staff to meet patient needs risks deterioration of the patient's health status and delayed treatment. Findings included: Failure to ensure that the number of assigned personnel allowed for treatment planning and delivery of care as ordered by the treatment team. Cross Reference: A0392, A0396, Failure to ensure that non-employee licensed nurses were properly orientated to the hospital's policies and procedures. Cross Reference: A0398 Failure to ensure that staff members followed hospital policy and procedure for transcription and verification of physician orders. Cross Reference: A0405 Due to the scope and severity of deficiencies cited under 42 CFR 482.23, the Condition of Participation for Nursing Services was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 03/15/18 AND 06/07/18.	A 385		
A 392	STAFFING AND DELIVERY OF CARE	A 392		

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A 392	Continued From page 36 CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: . Based on document review and interviews, the hospital failed to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT) risks patient safety and delays in care and treatment. Findings included: 1. Document review of the hospital document titled, "Nurse Staffing Plan," dated 05/17, showed that nursing care is to be provided by sufficient numbers of nursing staff members including registered nurses and licensed practical nurses to meet the identified nursing care needs of patients and family members twenty-four hours a day. Core staffing is projected based on the following critical factors: - Patient characteristics - The number of patients receiving care, including admissions, discharges and transfers	A 392		

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A 392	Continued From page 37 - Intensity of patient care being provided -The variability of patient care across the unit -The scope of services provided, accounting for architecture and geography of the unit - Staff characteristics, including staff consistency, tenure, preparation and experience - The number and competencies of both clinical and non-clinical support staff the nurse must collaborate or supervise. 2. A review of the daily nurse-staffing sheet for a fourteen-day period (12/23/18 - 01/05/19) showed the following: a. The adolescent inpatient unit, which cares for children ages 12 to 17, did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. In addition, one other night shift did not have a registered nurse assigned for a 4-hour period. b. The adult intensive care unit, which cares for adults with acute and significant behavioral disturbances did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. c. The open adult unit that cares for adults with first time symptomology for behavioral health illness did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. d. The military unit which cares for adults with service connected behavioral health illness did not have a registered nurse assigned to the night shift for 1 of 14 days reviewed. In addition, one other night shift did not have a registered nurse assigned for a 2.5-hour period.	A 392		

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A 392	Continued From page 38 3. On 01/08/19 at 9:10 AM, Surveyor #3 inspected the adolescent inpatient unit. At the time of arrival, the surveyor observed there were three patients on the unit with no licensed nursing personnel present. Two mental health technicians (MHT) (Staff #301 and #302) were the only staff members present. Staff #301 stated the registered nurse (Staff #303) and another MHT had gone to the cafeteria for breakfast with the patients a few minutes ago. A subsequent interview with the registered nurse upon return to the unit revealed that she usually does not leave the unit for meal times. She stated it is permissible to leave the unit as long as the unit is attended by another nursing staff member. 4. On 01/08/19 at 1:35 PM, Surveyor #5 observed Patient #501 approach the nurse's station and tell the Mental Health Technicians (MHT's) (Staff #501 and #502) at the nurses station that she was feeling shaky and weak and wanted her blood sugar tested. Surveyor #5 observed the patient ask to have her blood sugar tested two more times and then a Program Therapist (Staff #504) responded to the patient and asked for the nurse. The MHT's stated that the charge nurse (Staff #505) was at lunch and the other nurse (Staff #506) had left the unit. At that time, the Program Therapist left the unit to go get a nurse. At 1:42 PM, a nurse (Staff #506), returned to the unit and took the patient's blood sugar. At the same time, Surveyor #5 interviewed Staff #501 and #502 who verified that there is not always a nurse on the unit at all times. 5. On 01/10/19 at 7:00 PM, Surveyor #3 interviewed a registered nurse (Staff #304) about	A 392		

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A 392	Continued From page 39 adequacy of nurse staffing for the clinical units. The surveyor asked if there ever was a time when there was no registered nurse on the unit. Staff #304 stated it has happened several times. A licensed practical nurse is in charge of the unit when no registered nurse is available. Staff #304 recalled at least one incident in which there was only one registered nurse providing care and supervision for two clinical units but could not recall the date. 6. On 01/10/19 at 7:30 PM, Surveyor #3 interviewed a mental health technician (Staff #305) about staffing. Staff #305 stated that he has been left alone on the unit at times when the assigned registered nurse was providing care and nursing coverage on another unit. He indicated that the assigned registered nurse would leave the unit to pass medications on another unit and then return to pass medications on their assigned unit. 7. On 01/11/19 at 10:00 AM, Surveyor #3 reviewed the medical record of Patient #301 who was admitted to the adolescent unit on 12/29/18 for treatment of a mood adjustment disorder. The review of the medical record showed the following: -On 01/06/19 at 11:30 AM, a nurse wrote a nursing order for sexually acting out precautions and established a five-foot boundary rule from other patients after attempting sexual behavior in the patient's bathroom. -On 01/09/19 at 9:45 PM, a nursing progress note showed the patient required frequent reminders about his five-foot rule with female peers.	A 392		

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A 392	Continued From page 40 -On 01/10/19 at 6:30 PM, a note written by a MHT (Staff # 301) showed that Patient #301 had sexual contact with Patient #302 on 01/09/19. Patient #301 informed Staff #301 that the consensual sexual contact occurred in the female patient's room while the MHT was passing out snacks to other patients. A review of the nurse staffing for the adolescent unit on 01/09/19 showed that the hospital had only the minimum required staffing (1 RN and 1 MHT) at the time of incident. 7. On 01/16/19 at 9:25 AM, Surveyor #3 interviewed the Chief Nursing Officer (CNO) (Staff #306) about nurse staffing for the hospital. The CNO stated that the hospital uses a nurse-staffing grid that establishes minimum staffing levels for each of the clinical units. She stated she checks the nurse-staffing schedule several times a day to ensure the units are appropriately staffed. Shortfalls in staffing are covered by calling in staff for voluntary overtime or offering shift bonuses for extra hours worked. When asked what happens if this is not effective in resolving the shortage, the CNO stated, "We do what we can". She acknowledged there are occasions when the only licensed nurse staff member on a clinical unit is a licensed practical nurse (LPN). During those occasions, a registered nurse will supervise or cover more than one nursing unit at a time. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18 AND 06/17/18.	A 392		
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4)	A 396		

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A 396	Continued From page 41 The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: . Based on interview, record review, and review of policies and procedures, the hospital failed to develop an individualized plan for patient care for 5 of 15 patients reviewed (Patient #501, #502, #503, #504, and #902). Failure to develop an individualized plan of care can result in the inappropriate, inconsistent, or delayed treatment of patient's needs and may lead to patient harm and lack of appropriate treatment for a medical condition. Findings included: 1. Document review of the hospital's policy and procedure titled, "Treatment Planning," no policy number, effective date 05/17, showed that following the nursing assessment, the Registered Nurse will add medical problems to be addressed to the treatment plan. The treatment plan will be reviewed and updated weekly at Treatment Team meetings and will reflect changes in the patient's course of treatment. Document review of the "2018 {Infection Control} Risk Assessment and Plan & Evaluation," showed that one of the planned opportunities to decrease the risk of infectious disease included addressing infectious diseases on the medical care plan. Patient #501	A 396		

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A 396	Continued From page 42 2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The patient's medical history showed the patient underwent a gastric bypass surgery one and a half years ago. Surveyor #5 found no evidence that nutritional support was addressed in the patient's treatment plan. 3. At the time of the observation, Staff #505 confirmed the finding and stated that he would expect to see this added to the treatment plan. Patient #902 4. On 01/08/19 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902 who was admitted to the hospital on 01/05/19 with a diagnosis of acute psychosis and suicidal ideation. An initial medical consultation on 01/06/19 by a physician (Staff #903) showed a medical diagnosis of Hepatitis C was added to the patient's problem list. The physician ordered an outpatient consult with a gastroenterologist. Review of the treatment plan for Patient #902 did not include the diagnosis of Hepatitis C. 5. At the time of the record review, Surveyor #9 asked the Director of the Transitional Care Unit (Staff #902) if she would expect to see the diagnosis of Hepatitis C on the patient's treatment plan. She stated that the diagnosis should be there. On 01/16/19 at 1:00 PM during a meeting with the Infection Control Nurse (Staff #904), Surveyor #9 asked if she would expect to see the Hepatitis C diagnosis added to the treatment plan and she confirmed that infectious diseases	A 396		

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A 396	Continued From page 43 should be added to the treatment plan. Patient #502 6. On 01/08/19 at 3:00 PM, Surveyor #5 and the Infection Preventionist (Staff #507), reviewed the medical record for Patient #502, who was admitted for the treatment of schizo-affective disorder with methamphetamine abuse and attempted suicide. On 12/26/18, the patient was tested for Hepatitis A, B, and C related to abnormal liver function tests. On 12/31/18, the patient was diagnosed with Hepatitis C and was referred for consultation with gastroenterology or infectious disease upon discharge for possible treatment with interferon. Surveyor #5 found no evidence that staff added the new medical diagnosis to the patient's treatment plan. 7. At the time of the finding, Staff #507 stated that she was aware of the patient, and confirmed that staff should have added the new medical diagnosis to the medical section of the treatment plan. Patient #503 8. On 01/09/19 at 9:25 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #511) and a Licensed Practical Nurse (Staff # 512) reviewed the medical record of Patient #503, who was admitted for major depression, visual hallucinations, and suicidal ideation with intent to harm oneself. An initial medical consultation completed on 01/04/19 showed a medical diagnosis of Diabetes Mellitus Type 2. On 01/04/19, a provider ordered blood glucose checks twice daily. Surveyor #5 found no evidence that the medical problem of diabetes	A 396		

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A 396	Continued From page 44 was included in the patient's treatment plan. 9. At the time of the observation, Staff #511 confirmed the finding. Patient #504 10. On 01/11/19 at 9:30 AM, Surveyor #5 reviewed the medical record for Patient #504 who was admitted for the treatment of suicide attempt, depression, bipolar, schizoaffective disorder, and auditory hallucinations to harm self. A medical consultation completed on 09/26/18 at 12:24 PM, showed the patient had a rash on the right anterior chest suspicious for Shingles. The provider's examination showed the patient had greater than 12 painful vesicles on the right chest. The patient was started on Acyclovir 800 mg 5 times daily for 7 days. Surveyor #5 found no evidence that staff added the new medical diagnosis to the patient's treatment plan. On 10/06/18 at 4:00 PM, a medical consultation showed the patient had a red rash to the inguinal and groin regions. The patient was treated with fluconazole 100 mg daily for 7 days and antifungal powder for the treatment of intertigo (a rash caused by fungus or bacteria that usually affects the folds of the skin, where the skin rubs together, or where it is often moist) and candidiasis (a fungal infection). On 10/15/18 at 11:40 AM, a medical consult was ordered for increased redness and itching around the groin area. A provider ordered Doxycycline 100 mg daily for 7 days for intertigo. Surveyor #5 found no evidence that the medical diagnosis was included in the patient's treatment plan. THIS CITATION WAS PREVIOUSLY CITED ON	A 396		

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A 396	Continued From page 45 03/15/18 AND 06/17/18.	A 396		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that contracted nurses received documented hospital orientation for 1 of 3 files reviewed (Staff #205) (Item #1), and failed to complete annual agency staff performance evaluations for1 of 3 staff members reviewed (Staff #205) (Item #2) . Failure to ensure contracted nursing staff receive orientation to the hospital policies and procedures and receive annual performance evaluations places patients at risk for inconsistent or inadequate care. Item #1 - Non-Employee Nurse Orientation Findings included: 1. Record review of the personnel and training files for a contracted registered nurse (Staff #205) with a start date of 10/23/17, showed that no documentation of an orientation or training regarding nursing policies and procedures,	A 398		

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A 398	Continued From page 46 emergency procedures, or safety policies were in the file. 2. On 01/16/18 at 10:00 AM, Surveyor #2 interviewed the clinical educator (Staff #210) regarding the training files for Staff #205. Staff #210 stated that staff have 90 days to complete orientation and confirmed that Staff #205 did not have any orientation or training documents in their personnel file. Item #2 - Non-Employee Nursing Evaluation Findings included: 1. Record review of the hospital policy titled "Evaluations," reviewed 04/18, showed that staff receive an evaluation 90 days post-hire and annually. The policy does not mention evaluations of contracted or agency staff. 2. Record review of the personnel file for a contracted registered nurse (Staff #205) with a start date of 10/23/17, did not show evidence that the hospital conducted a performance evaluation of the staff member one year after initial employment. 3. On 01/16/18 at 9:45 AM, Surveyor #2 interviewed the Human Resources Director (Staff #211) and the Vice President of Human Resources (Staff #212) regarding employee evaluations. The Human Resources Director stated that the hospital should evaluate agency staff at the end of their contract under the same process as hospital employees and the performance improvement department should be performing an overall evaluation of all contracted staff. Staff #211 confirmed the finding of the	A 398		

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A 398	Continued From page 47 missing employee evaluation.	A 398		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on record review and review of hospital policy and procedures, the hospital staff failed to follow its procedure for transcribing physician orders to the medication administration record for 4 of 7 patient records reviewed (Patient #301, #302, #303 and #904). Failure to transcribe and process physician orders promptly places patients at risk for delayed	A 405		

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A 405	Continued From page 48 treatment and medication errors. Findings included: 1. Document review of the hospital's policy and procedure titled, "Physician Orders," no policy number, effective 05/17, showed that the nurse will transcribe medication and treatment orders. Any medication order transcribed to the medication administration record (MAR) is to be checked for accuracy by a second nurse during the chart check (at shift change and 24-hour chart check). Staff will ensure a copy of all medication orders, including as needed orders, are delivered without delay to the Pharmacy mailbox. Document review of the hospital's policy and procedure titled, "Written Medication Orders," no policy number, effective 05/17, showed that nursing staff will forward the written copy of the order to pharmacy in a timely manner. 2. On 01/09/19 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #301. The review showed that on 01/02/19 at 11:59 AM, a provider wrote a medication order for Depakote (medication used for mood disorders). The medication order was transcribed to the medication administration record (MAR) and sent to the pharmacy at 8:30 PM, over eight and one-half hours after being initially ordered. As a result, Patient #301 did not receive the medication in the evening as ordered due to the pharmacy being closed. 3. On 01/09/19 at 11:15 AM, Surveyor #3 reviewed the provider medication orders for five patients. The review showed:	A 405		

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A 405	Continued From page 49 a. Patient #302 had seven new medication orders written by a provider between 11/26/18 and 12/31/18 in which they were not transcribed by the nurse to the medication record for greater than 3 hours. The delay in transcribing ranged from 3 hours and 10 minutes to 8 hours and 45 minutes. b. Patient #303 had one new medication order written by a provider on 12/13/18 at 7:00 PM but was not transcribed by the nurse until 12/16/18 at 1:00 AM, which is 2 days and 6 hours after being originally ordered. 4. On 01/10/19 at 10:40 AM, Surveyor #9 and Surveyor #11 interviewed a provider (Staff #907) regarding an allegation that Patient #904 had not received a medication as ordered and subsequently was not discharged as planned due to psychiatric decompensation. The provider stated that he ordered lorazepam 1 mg (a medication used to treat anxiety) to be administered to the patient three times a day. The original order written on 12/26/18 had an expiration date of 01/02/19. The provider stated that he reordered the medication on 01/02/19. On 01/04/19, the provider noted that the patient seemed more anxious. He reviewed her medications, looked at the patient's medication administration record (MAR), and discovered that 5 doses of lorazepam (2 days) had not been given. Further, the MAR did not reflect the renewal order for continuing the lorazepam as ordered on 01/02/19. Document review for Patient #904 showed the following:	A 405		

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A 405	Continued From page 50 a. The MAR reflected that Lorazepam was ordered on 12/26/18 by the provider and was to be given three times a day. -On 01/01/19 to 01/02/19 the medication lorazepam was only given twice a day (due to the MAR not being transcribed correctly). -On 01/02/19 to 01/03/19 the medication lorazepam was not transcribed on the MAR and therefore was not given to the patient. -On 01/03/19 to 01/04/19 the medication lorazepam was not transcribed on the MAR initially but added later after discovering the error. As a result, the patient only received the medication twice that day. - A total of 5 doses of the medication lorazepam were missed from 01/01/19 to 01/04/19. b. On 12/31/18, a reorder form for drugs expiring between 12/31/18-01/02/19 showed that the provider reordered the medication lorazepam. There were two stamped "Faxed" dates on the medication reorder form. One had no date noted and the second medication reorder form showed the order was refaxed on 01/04/19. 5. The provider stated that when he discovered this, he contacted the Chief Nursing Officer (Staff #906) and submitted an incident report to the pharmacy. Surveyor #9 was unable to find an incident report regarding this error despite a review of the hospital's Medication Error Incident Reports. 6. On 01/16/19 at 10:30 AM, Surveyor #9 discussed this finding with the Pharmacy Director	A 405		

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A 405	Continued From page 51 (Staff #908). Staff #908 stated that he had not received an incident report on this error; however, around 01/02/19 he found that faxes were not being received in the pharmacy leading to duplications on orders. Additionally, he stated the process to verify the MAR was not clearly defined which led to errors. The Pharmacy Director (Staff #908) changed the reorder process so that medication orders are now scanned to pharmacy. The scanned orders are in a database that is accessible to pharmacy, physicians, and nursing to enable clarification and avoid duplications and missed orders. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18, 06/17/18, AND 07/17/18.	A 405		
A 454	CONTENT OF RECORD: ORDERS DATED & SIGNED CFR(s): 482.24(c)(2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based on record review and review of hospital policies and procedures, the hospital failed to ensure medical staff promptly signed and authenticated verbal or telephone orders taken by a nurse for initiation of seclusion or restraint as observed in 2 of 4 records reviewed (Patient # 303, #1001).	A 454		

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A 454	Continued From page 52 Failure to authenticate verbal or telephone orders for initiation of seclusion risks treatment errors and violation of patient rights. Findings included: 1. Document review of the hospital's policy and procedure titled, "Use of Seclusion," no policy number, effective 05/17, showed that the physician's order governs the use of seclusion and the order will include the behavior that led to the intervention. The policy showed that the orders for seclusion must be authenticated within 24 hours. Document review of the medical staff rules and regulations, approved 05/31/17, showed that seclusion and/or restraint procedures require an order from the physician. In the event of an emergency, the registered nurse can initiate the procedure but must obtain an order. Seclusion and/or restraint orders must be authenticated by the physician within 24 hours. 2. On 01/09/19 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #303. Patient #303 was a 14-year old admitted on 12/01/18 for major depressive disorder. The surveyor reviewed five episodes of manual physical holds and seclusion events from 12/15/18 to 12/23/18. No physician signature could be found authenticating the telephone order received by the registered nurse for seclusion episodes that occurred on 12/20/18 and 12/21/18 in the medical record. 3. On 01/11/19 at 10:45 AM, Surveyor #10 reviewed Patient #1001's medical record that showed a 13-year old patient admitted to the	A 454		

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A 454	Continued From page 53 adolescent unit for management of a mental health disorder. On 12/01/18 at 2:45 PM, the record showed that the patient was observed punching a wall resulting in harm to himself as staff attempted to de-escalate the situation. The record showed that the patient initially was placed in a manual hold from 2:45 PM to 2:50 PM, followed by being placed in seclusion from 2:45 PM to 3:00 PM. The nurse obtained a verbal order from a licensed provider at 3:30 PM and included the behavior that led to the intervention. At the time of the review, the verbal order had not been authenticated by a licensed provider's signature as required by policy.	A 454		
A 505	UNUSABLE DRUGS NOT USED CFR(s): 482.25(b)(3) §482.25(b)(3) - Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use This STANDARD is not met as evidenced by: Based on observation, interview, and review of hospital policy and procedures, the hospital failed to ensure appropriate disposal of unusable medications. Failure to ensure medication storage areas are devoid of outdated or otherwise unusable medications puts patients at risk for receiving medications with compromised sterility, integrity, or stability. Findings included: 1. Document review of the hospital's policy and procedure titled, "Multi-Dose Vials," no policy	A 505		

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A 505	Continued From page 54 number, effective date 05/17, showed that all multi-dose vials must be dated with a 28 day expiration date and initialed with the time of the original opening by the person initially accessing the multi-dose vial. 2. On 01/09/18 at 8:53 AM, Surveyor #5 and a Program Director (Staff #508) inspected the medication room on the Adult Unit. Surveyor #5 observed two opened partially used multi-dose vials of diphenhydramine 500 mg per ml (an antihistamine) sitting on top of the medication-dispensing machine. The bottles did not contain a label with an expiration date or the initials of the staff initialing accessing the bottle. 3. At the time of the observation, Staff #508 confirmed the finding and removed the vials. 4. On 01/19/18 at 10:15 AM, Surveyor #9 and the Program Director (Staff #902) of the Transitional Care Unit (TCU) inspected the TCU medication room. Surveyor #9 found three opened partially used vials of injectable bacteriostatic water in a cabinet. The bottles did not have a label with an expiration date or the initials of the staff who accessed the vial. 5. At the time of the observation, Staff #902 confirmed the finding and removed the vials.	A 505		
A 629	THERAPEUTIC DIETS CFR(s): 482.28(b), (b)(1) §482.28(b) Menus must meet the needs of patients. (1) Individual patient nutritional needs must be	A 629		

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A 629	Continued From page 55 met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that patients with medical conditions or histories that necessitate dietary consults received consults or that consults ordered by dieticians were conducted for 2 of 10 records reviewed. (Patient #501, #901) Failure to ensure that patients needing dietary consults receive nutritional assessments risks improper nutrition that could lead to unanticipated patient outcomes. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nutritional Service for Patients," no policy number, effective 05/17, showed that a nurse will perform a nutritional screen and initiate a dietary consult when a potential for malnutrition has been identified or the patient has a medical disorder such as diabetes. 2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The patient had a medical history of Diabetes Mellitus Type II and a blood sugar of 387 documented in the Emergency Room prior to admission to the psychiatric hospital. The patient's history showed the patient had underwent gastric bypass surgery one and a half years ago. On 01/06/19 at 12:30 AM, a provider ordered a regular diet and an ADA diet (American	A 629		

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A 629	Continued From page 56 Diabetic Association diet). Surveyor #5 and Staff #505 found no evidence that staff obtained a clarification order for which diet was correct. Surveyor #5 and Staff #505 reviewed the patient's dietary card and found the patient was receiving a diabetic diet. Surveyor #5 and Staff #505 reviewed the dietician consult form and found the patient received a nutritional screen but did not need a dietician's consultation. 3. At the time of the observation, during an interview with Surveyor #5, the Registered Nurse (RN) (Staff #505) stated that patients with diabetes should receive a dietary consult. The nurse was unaware that the patient had a gastric bypass surgery. 4. On 01/16/19 at 2:23 PM, Surveyor #5 and Surveyor #2 interviewed a dietician (Staff #510) about the dietary consultation process. Staff #510 stated that nursing staff complete a nutritional screening upon admission. She would only become aware of a patient's diagnosis requiring a dietary consult if she received a dietary consultation request. She stated that she did not receive a dietary consultation request for this patient. She stated that nursing staff completes the dietary order card and sends it to the dietary staff. The dietician does not reconcile the cards sent from the nursing staff against the physician diet order. 5. On 01/09/19 at 11:45 AM, Surveyor #9 reviewed the medical record of Patient #901 who was admitted on 10/15/18 with a diagnosis of depression and psychosis. The record review showed that the patient had an initial medical consult on 10/16/18 that identified his concurrent diagnosis of diabetes type 2, hypertension (high	A 629		

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A 629	Continued From page 57 blood pressure), and hyper cholesteremia (high cholesterol). The physician (Staff #901) conducting the medical consultation ordered a dietary consult. As of 01/09/19, a dietary consult had not been completed. 6. At the time of the medical record review, Surveyor #9 interviewed the Director of Transitional Care Unit (Staff #902) about the lack of a dietary consult. She acknowledged that the dietary consult was not in the record and it appeared it was not completed. She took action at this time to contact the dietician for a consult.	A 629		
A 631	THERAPEUTIC DIET MANUAL CFR(s): 482.28(b)(3) A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that the medical staff and dietician approved a diet manual per hospital policy. Failure to approve a diet manual risks patients receiving inadequate nutrition. Findings included: 1. Record review of the hospital policy titled, "Diet Manual," effective 05/17, showed that the medical director and the dietician are required to review the diet manual annually.	A 631		

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A 631	Continued From page 58 Record review of the diet policies showed that the hospital last reviewed them on 05/17. 2. On 01/16/19, Surveyors #2 and #5 interviewed the dietician (Staff #204) regarding dietetic services. The dietician stated that she had not reviewed the diet manual annually and had not reviewed it with the medical staff.	A 631		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: . Based on observation and interview, and review of hospital policies and procedures, the hospital staff failed to ensure patient care supplies were not stored or available for patient use beyond the manufacturer's expiration date (Item #1), failed to verify that emergency supplies and equipment were available and ready for use (Item #2), and failed to ensure staff performed quality control checks for blood sugar point of care testing as required (Item #3). Failure to ensure that patient care supplies are ready for use and not expired, risks ineffective patient care and treatment, as well as potential patient harm. Item #1 - Expired Supplies Findings included:	A 724		

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A 724	Continued From page 59 1. On 01/08/19 at 9:35 AM during an inspection of the adolescent unit, Surveyor #3 found the following items in the medication room: a. One bottle of urine drug screening dipstick tests with an expiration date of 08/18. b. One package of Streptococcal A dipstick rapid test with an expiration date of 09/30/18 c. One bottle of Streptococcal A regent 1 control agent with an expiration date of 12/28/18. d. One bottle of Streptococcal A regent 2 control agent with an expiration date of 01/04/19. e. One package of Streptococcal A controls with an expiration date of 01/04/19. f. One bottle of Chemstrip urine test strips with an expiration date of 09/30/18. 2. On 01/08/19 at 10:15 AM, Surveyor #2 inspected the laboratory area of the hospital. During the inspection, the surveyor observed the following expired supplies: a. 9 BD Vacutainer UA Transfer Straw Kits with an expiration date of 05/18 b. 16 BD Vacutainer C&S Transfer Kits with an expiration date of 05/18 c. 59 UTM-RT Specimen Collection Kits with an expiration date of 11/18 d. 27 OC-Auto Personal Use Kits with an expiration date of 09/20/18	A 724		

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A 724	Continued From page 60 e. 1 container of Chemstrip 10 MD - Cobas UA Strips with an expiration date of 09/30/18. 3. During the observation, Surveyor #2 interviewed a facilities engineer (Staff #201) who confirmed the observations. 4. On 01/08/19 at 2:00 PM, Surveyor #5, a Registered Nurse (Staff #507), and a Program Manager (Staff #503) inspected an emergency cart located in the Intensive Care Unit. Surveyor #5 observed one container of Cavi wipes with a manufacturer's expiration date of 09/01/18. 5. At the time of the observation, Surveyor #5 asked Staff #507 and Staff #503 about how the hospital checked for outdated supplies on the locked cart. Staff #507 stated that the hospital did not have a system in place. 6. On 01/09/19 at 9:00 AM, Surveyor #5, a Program Director (Staff #508), and a Licensed Practical Nurse (LPN) (Staff #509) inspected the medication room on the hospital's Adult Unit. Surveyor #5 observed four intravenous start kits with a manufacturer's expiration date of 03/18 and one urinalysis vacutainer transfer kit with a manufacturer's expiration date of 09/18. 7. At the time of the observation, Staff #508 and #509 confirmed the finding and removed the supplies. Item #2 - Emergency Cart Checks Findings included: 1. Document review of the hospital's policy and procedure titled, "Emergency Drugs and Supplies	A 724		

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A 724	Continued From page 61 - Crash Cart," no policy number, effective 12/17, showed that the crash cart will be inspected after each use and each month to ensure completeness of contents. Document review of the instructions for the crash cart checklist showed that night shift would check the cart daily, initial each box, and sign at the bottom of the sheet. On the first of the month, the crash cart is opened and checked for expired items. 2. On 01/08/19 at 9:35 AM during a tour of 2-North, Surveyor #3 inspected the emergency cart. A review of the emergency cart checklist logs showed that cart checks were missing for 12 of 30 days in November 2018, for 14 of 31 days in December 2018, and were missing the first 7 days of January 2019. 3. On 01/08/19 at 9:35 AM, Surveyor #3 interviewed the Program Manager (Staff #307) about the missing emergency cart checks. She stated the night shift nursing staff were responsible for performing the checks. 4. On 01/08/19 at 2:00 PM, Surveyor #5 and a Program Manager (Staff #503) inspected an emergency cart located in the Intensive Care Unit. The observation showed missing or partial completion of cart checks for 2 of 8 days in January 2019 and 14 of 31 days in December 2018. At the time of the observation, Staff #503 confirmed the finding. Item #3 - Point of Care Testing Quality Control Checks	A 724		

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A 724	Continued From page 62 Findings included: 1. Document review of the hospital's policy and procedure titled, "Glucose Monitoring," no policy number, effective 05/17, showed that on a daily basis, the glucometer will be checked by the night shift staff using the normal control solution obtained from the manufacturer. 2. On 01/08/19 at 10:35 AM, Surveyor #3 inspected the adolescent unit's medication room. During the inspection, the surveyor reviewed the point of care testing blood sugar quality control record sheets. The review showed that quality control checks for the glucometer were missing for 7 of 30 days in November 2018, 11 of 31 days in December 2018, and 7 of 8 days in January 2019. 3. An interview with the Program Manager (Staff #307) at the time of the observation confirmed these observations. She stated the hospital policy is that glucometer quality control checks are done daily.	A 724		
A 726	VENTILATION, LIGHT, TEMPERATURE CONTROLS CFR(s): 482.41(d)(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation and record review, the hospital failed to ensure that staff were monitoring refrigeration temperatures to ensure proper cold	A 726		

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A 726	Continued From page 63 holding of patient food items. Failure to ensure that refrigerators maintain patient food items at proper cold holding temperatures risks food-borne illness. Findings included: 1. Record review of the hospital policy titled, "Food Storage," no policy number, effective date 05/17, showed that staff are to check and record temperatures twice a day. 2. On 01/10/19 at 7:00 PM, Surveyors #2 reviewed a refrigeration log from the first floor patient refrigerator. Hospital staff had not checked or recorded the temperature since 01/01/19. Reference: 2009 FDA Food Code 3-501.16	A 726		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on interview, review of hospital policies and procedures, and personnel file review, the hospital failed to ensure that staff members put specific precautions in place for patients diagnosed with infectious disease to prevent	A 749		

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A 749	Continued From page 64 transmission of infections (Item #1,#2); and failed to ensure that contracted staff members received infection control training specific to their jobs (Item #3). Failure to ensure that staff members implement appropriate isolation procedures for patients with infections and failure to provide appropriate infection control education to contracted employees puts patients and staff members at risk of infection from communicable diseases. Item #1- Herpes Zoster Reference: Centers for Disease Control and Prevention, "Preventing Varicella-Zoster Virus (VZV) Transmission from Zoster in Healthcare Settings," reviewed 10/17/17, states that if a patient is immunocompetent with localized herpes zoster, then standard precautions should be followed and lesions should be completely covered. If the patient is immunocompetent with disseminated herpes zoster, then standard precautions plus airborne and contact precautions should be followed until lesions are dry and crusted. Findings included: 1. Document review of the hospital's policy and procedure titled, "Infection Control Policies Subject: Isolation procedures," no policy number, date issued 05/17, states that standard precautions plus contact precautions should be used for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or items in the patient's environment.	A 749		

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A 749	Continued From page 65 2. On 01/11/19 at 9:30 AM, Surveyor #5 reviewed the medical record for Patient #504 who was admitted for the treatment of suicide attempt, depression, bipolar, schizoaffective disorder, and auditory hallucinations to harm self. A medical consultation completed on 09/26/18 at 12:24 PM, showed the patient had a rash on the right anterior chest suspicious for Shingles. The provider's examination showed greater than 12 painful vesicles on the right chest. The patient was started on Acyclovir 800mg 5 times daily for 7 days. Surveyor #5 found no evidence the lesions were covered or the patient was placed on contact precautions. 3. On 01/16/19 at 2:00 PM, Surveyor #9 and the Infection Control Nurse (ICN) (Staff #904) reviewed the medical record of Patient #504. The ICN noted that staff did not report this condition to her. She agreed that the patient should have been placed in contact isolation. Item #2- Hepatitis C Reference: Centers for Disease Control and Prevention, Division of STD Prevention, National Center for HIV/AIDS,STD, and TB Prevention (last reviewed 06/06/15) stated that Hepatitis C can be transmitted through exposures in health care settings as a consequence of inadequate infection control practices. Findings included: 1. Document review of the hospital's policy and procedure titled, "Isolation Procedures," issued 05/17 showed that standard precautions will apply to blood; all bodily fluids and secretions, except sweat; non-intact skin; and mucous membranes.	A 749		

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A 749	Continued From page 66 The document showed that standard precautions are combined with disease-specific precautions when a disease is identified. Document review of the "2018 {Infection Control} Risk Assessment and Plan & Evaluation," showed that one of the planned opportunities to decrease risk of infectious disease included addressing infectious diseases on the medical care plan. 2. On 01/08/19 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902, admitted to the hospital on 01/05/19 with a diagnosis of acute psychosis and suicidal ideation. The record review showed that a physician (Staff #903) conducted an initial medical consultation on 01/06/19 with a medical diagnosis of Hepatitis C added to the patient's problem list. The physician ordered an outpatient consult with a gastroenterologist. Review of the treatment plan for Patient #902 did not include the diagnosis of Hepatitis C. 3. At the time of the record review, Surveyor #9 asked the Director of the Transitional Care Unit (Staff #902) if she would expect to see the diagnosis of Hepatitis C on the patient's treatment plan. She stated that the diagnosis should be there. On 01/16/19 at 1:00 PM during a meeting with the Infection Control Nurse (Staff #904), Surveyor #9 asked if she would expect to see the Hepatitis C diagnosis added to the treatment plan and she confirmed that infectious diseases should be added to the treatment plan. 4. On 01/08/19 at 3:00 PM, during record review, Surveyor #5 reviewed the medical record of Patient #503, admitted on 12/15/18 for suicide attempt, schizoaffective disorder, and	A 749		

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A 749	Continued From page 67	A 749		

methamphetamine abuse. On 12/31/18, the patient was diagnosed with Hepatitis C and was referred for consultation with gastroenterology or infectious disease upon discharge for possible treatment with interferon. On 12/31/18, the record showed that a medical provider (Staff #909) wrote an order for the patient to be in "Enteric Precautions" for Hepatitis C. The patient's Kardex dated 12/27/18 showed that "Enteric Precautions" had been noted, but was crossed out and replaced with "Standard Precautions." Further review of the patient's record of every 15 minute rounding for 01/02/19, 01/03/19, 01/04/19, 01/05/19, and 01/06/19, showed the patient is noted to be in "Contact Precautions".

5. On 01/16/19 at 2:00 PM, Surveyor #9 and the Infection Control Nurse (ICN) (Staff #904) reviewed the medical record of Patient #905. The ICN stated that staff did not appear to have an understanding of what type of precautions measures should be in place for this patient who should have been in "Standard Precautions".

Item #3 - Infection Control Training

Findings included:

1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on infection control and human resources is to maintain documentation of all training completed by staff.

2. Record review of employee personnel and training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of orientation regarding infection control.

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A 749	Continued From page 68 3. On 01/16/18 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18.	A 749		
A 811	DISCUSSION OF EVALUATION RESULTS CFR(s): 482.43(b)(6) The hospital ... must discuss the results of the evaluation with the patient or individual acting on his or her behalf. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to include the family of a patient in the discharge planning process for 1 of 1 patients reviewed (Patient #515). Failure to include the family in the discharge planning process places patients at risk for readmission to the hospital. Findings included: 1. Document review of the hospital's policy and procedure titled, "Discharge Planning," no policy number, effective date, 05/17 showed the discharge planning process will include timely and direct communication with and transfer of information to other programs, agencies, or individuals that will be providing continuing care. When developing aftercare plans, the hospital	A 811		

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A 811	Continued From page 69 must consider: -Family relationships; -Physical and psychiatric needs; -Financial needs; -Housing needs and/or placement issues; -Employment needs; -Educational/vocational needs; -Social and recreational needs; -Accessibility to community resources; -Personal support systems; -Spiritual needs; -Transportation problems related to aftercare treatment; - Potential for recidivism 2. On 01/10/18, Surveyor #5 reviewed the medical record for Patient #515, who was admitted on 10/28/18 for the treatment of personality disorder, depression, anxiety, and rule out psychosis. The review showed: a. The intake assessment completed on 10/28/18 showed the patient had been living with his father, but could not return after discharge. b. Psychosocial assessment completed on 10/30/18 showed the patient is homeless. c. On 11/24/18, nursing staff documented in the nursing notes that the patient's mother requested a family session to discuss the patient's "care, housing, and other things." d. On 11/25/18, a provider documented in the psychiatric progress notes that the mother requested a family session to discuss the patient's care.	A 811		

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A 811	Continued From page 70 e. On 11/26/18, a provider documented in the psychiatric progress notes his discussion with the patient regarding discharge that included a potential option to live with his mother. The psychiatric progress note stated that the mother "needed" a family session. 3. Surveyor #5 found no evidence in the medical record that a family session or meeting with the patient's mother occurred related to the care and discharge plan for the patient as requested. 4. On 01/10/18 at 12:00 PM, during interview with Surveyor #5, a Program Therapist (Staff #515) stated that the request for a family session was not communicated and did not occur. She stated that it was the responsibility of the program therapist to set up a meeting if the family requests one and requests for these meetings should have been discussed in the treatment team meeting. Staff #515 stated that the hospital recently changed the discharge planning process and the program therapists are now responsible for doing discharge planning.	A 811		